STATE OF WYOMING DEPARTMENT OF HEALTH END STAGE RENAL DISEASE PROGRAM

6101 Yellowstone Road, Suite 420, Cheyenne Wyoming 82002

APPLICATION FOR END STAGE RENAL DISEASE PROGRAM

If a line or box does not apply to you, please indicate by N/A

Applicant's Name (Please Print)			
Physical Address		First	Middle Initial
CityState	Zip	Phone # ()	
Mailing Address (P.O Box)	City _	State	Zip
SSN# Gende	r: M F	Date of Birth (MM/DD/YYYY)	/
Applicant's Primary Physician		Phone	
Applicant's Nephrologist		Phone	
Primary Dialysis Clinic		Phone	
Date of First Dialysis//	Tran	splant Yes No If Yes - Date	//_
Marital Status: S M W Sep Number In Hou	sehold:	Number of Dependent Children	
Total Gross Household Income (Before Taxes) Yea	arly \$	/ Monthly \$	
Family member or Friend whom we may contact if t	nable to reach	you:	
Name:		Phone:	
<u>Primar</u>		Center Information Print Legibly)	
Dialysis Center Name:			
Address:		<u> </u>	
City:	State:	Zip: tter from your physician confirming yo	our kidney
	_	r application.	·
Confirmation that a preliminary determ		Clease Complete) Ligibility has been performed at the	Dialysis Center.
Signature of Case Worker:		Phone:	
Printed name of Case Worker:		CW E-mail:	
ESRD PI	ROGRAM (OFFICE USE ONLY	
Financially Eligible Yes or No ESRD Progra (If applicant does not qualify due to financial guidelines, a			
Medically Eligible Yes or No			
Director/State Health Officer:		Date:	

HEALTH INSURANCE

A.	Do you have private health insurinformation; attach copies (front and b					ase include the following of of premium amount.
	Health Insurance Company Name	Type	of Coverage	Effecti	ve Date	Policy Number
	Monthly Premiums (Applicant only)	\$				
В.	Do you have Medicare? Ye following information and attach copies			out have a r Medicar		If yes, please complete the
	Type of coverage (check each box that applies)		Effective Dat	e	M	ledicare ID Number
	Part A Part B Part D					
	Monthly Premiums		Part B \$		Pa	art D \$
	following information and attach copie Type of Coverage (if known)	Effectiv	•	r Medical		d ID Number
D.	Do you have Indian Health Serv			Yes		□ No
Fo	e you receiving or have you applied for undation, the Wyoming Renal Foundation ease provide details:	assistance	•	organizat	tion, such a	•

END STAGE RENAL DISEASE PROGRAM

Confidential Financial Statement

APPLICANT'S PERSONAL INCOME	SPOUSE OR OTHER HOUSEHOLD INCOME
Employer / Occupation:	Employer / Occupation:
City/State:	City/State:
Gross Earnings from Employer: \$	Gross Earnings from Employer: \$
Monthly Social Security (Gross): \$	Monthly Social Security (Gross): \$
Monthly Retirement Income (Gross): \$	Monthly Retirement Income (Gross): \$
Monthly Disability Income and Source: \$ Source:	Monthly Disability Income and Source \$ Source:
Monthly Income from any other Source \$	Monthly Income from any other Source \$
Total Gross Income Last Year \$	Total Gross Income Last Year \$
→ Attach a Filed Copy of your most recent Income Tax Return. If you did not file a tax return, send a letter of explanation along with all documentation of all income.	→ Attach a Filed Copy of your most recent Income Tax Return. If you did not file a tax return, send a letter of explanation along with all documentation of all income.
BUSINESS, FARM, OR OTHER INCOME	Amount \$
Yearly Farm or business Income (if listed, please attach an itemized statement of business income and expenditures).	
Yearly Income from any sources other than shown above (rental property you own, dividends, interest, welfare, unemployment compensation, per capita payments, part – time jobs, second jobs, child support, etc.).	

Current Income If Different From Above

APPLICANT'S PERSONAL INCOME	SPOUSE OR OTHER HOUSEHOLD INCOME
Source: Amount: \$	Source: Amount: \$
Source: Amount: \$	Source: Amount: \$
Source: Amount: \$	Source: Amount: \$

FINANCIAL DATA

Assets (All Household Members)

	Remarks	
Estimated Market Value of Home	\$	
Value of Other Real Estate	\$	
Stocks and/or bonds (name and value)	\$	
Retirement Funds/IRA Accounts	\$	
Name of Bank(s)	\$	
Amount in Savings	\$	
Amount in Checking	\$	
Farm or business equipment value	\$	
Other Assets (Describe in remarks)	\$	
Other Assets (Describe in remarks)	\$	

Monthly Medical Expenses (Applicant Only)

Medical Insurance Information – Expenses for Applicant ONLY

Company	Policy Holder	Policy #	Monthly Premium *

^{*}If the medical insurance premium covers applicant and spouse and/or children, put the <u>applicant's share only</u> of the premium in the Monthly Premium box. **Please provide documentation of this expense with your application.**

Applicant's Medical Payments (ESRD Related Expenses for Applicant ONLY)

Туре	Monthly Payment	Balance Owed
Physician		
Hospital		
Dental		
Prescriptions		
Other Medical Only (list)		

Please include documentation of any ESRD related expenses claimed in this section.

OTHER:

Please use this space to describe any other expenses, assets, or income not covered above. If more space is needed, please use a separate page.

ASSISTANCE REQUESTED

The financial ability of ESRD to help with payments for services is restricted to those specifically related to Dialysis or to the payment for immunosuppressant medication for those who have had a kidney transplant. Please complete the following so ESRD can plan for expenses on your behalf. Should your situation change, please contact the ESRD office so your needs can be assessed to serve you best.

I need assista	nce with:
	Transplant Applicants : Only Prescription's for Immunosuppressant Medications are covered.
	Prescription costs (ESRD Approved Medications Only).
and	Co-payment after Medicare/Medicaid/IHS and/or Private Health Insurance have paid for dialysis d office visits related to my end stage renal disease.
	Reimbursement of private medical insurance premium (for myself only).
	Reimbursement of Medicare B premium (for myself only).
	Reimbursement of Medicare D premium (for myself only).
	Reimbursement of cost of Medical supplies for Home dialysis.
	Mileage for travel to Dialysis, (For travel outside your city of residence only).
	Home Address: (No PO Boxes)
	City: State: Zip:
	Other Must have approval by the ESRD Program.
Department of	t's Name), am applying for assistance to the Wyoming f Health, End Stage Renal Disease Program (ESRD). I am unable to pay for the recommended treatment. I apply all hospital and or medical insurance and Medicare benefits I receive to the cost of my care.
<u>I UN</u>	PERSTAND THAT THE END STAGE RENAL DISEASE PROGRAM (ESRD) WILL ONLY PAY FOR SERVICES / EXPENSES RELATED TO MY RENAL DISEASE ACCORDING TO ESRD PROGRAM POLICIES & PROCEDURES.
	ALL INFORMATION GIVEN ON THIS CONFIDENTIAL APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.
Applicant's Sign	nature: Date:

STATE OF WYOMING DEPARTMENT OF HEALTH END STAGE RENAL DISEASE PROGRAM

6101 Yellowstone Road, Suite 420, Cheyenne Wyoming 82002 Office: (307) 777-3527

Authorization to Furnish Information

Applicant's Name:	(Please print legibly)
Applicant's Date of Birth:	
The information you have provided will remain confident following circumstances:	tial with the Department of Health, <u>EXCEPT</u> in the
The End Stage Renal Disease Program (ESRD) as part of may request from any state agency, insurer, group healt entity any or all of your protected health information. T security number, amount of payment, charge for service medical payment. This information may be used or d healthcare operations. This is in accordance with the He section $164.502(a)(1)(ii)$. Please refer to the Notice of protected health information.	th plan, health maintenance organization or similar his information includes the recipient's name, social is, date of services, and services rendered related to isclosed for the process of treatment, payment or ealth Information Portability and Accountability Act
I hereby authorize the release of information limited to agencies, insurers, group health/dental plans, third party similar entities for the purpose set forth above.	
End Stage Renal Disease Program provides financial assis specifically relating to dialysis for those who have the individuals who have had a kidney transplant, the program	diagnosis of End Stage Renal Disease. For those
By signing this consent, I give my permission to medical h Centers, and insurers to release confidential medical information	
A photo copy or reproduction of this authorization is as va	llid as the original.
Signature of Applicant:	Date:
Signature of Witness:	Date:

This page is to help you submit a complete application and help ESRD to process your application as quickly as possible. Please read all instructions prior to posting your application. Thank you.

ESRD APPLICATION CHECK LIST

HAVE YOU:	
	Filled out the application completely (no empty lines or boxes);
	Included your physical address along with your mailing address;
	Signed and dated the application;
	Read the authorization statement;
	Signed and dated the authorization statement;
	Had a witness sign and date the authorization statement;
	Had your social worker sign and date the application;
	Included a photocopy of your income tax return for the most recent year or an explanation of why there is no tax return;
	Included proof of your current income from all sources;
	Included documentation of any claimed ESRD related expenses;
	Included a copy of your most recent Social Security benefit letter;
	Included a copy of your Social Security Card;
	Included your CMS 2728 medical form from physician (or a letter of confirmation from your doctor if you are a kidney transplant recipient);
	Included photocopies of <u>all</u> your health coverage identification cards (front and back);
	Included proof of private health insurance premium, if relevant;
	Included proof of Wyoming residency?

When complete, **send all seven pages** of this application and documentation to:

End Stage Renal Disease Program 6101 Yellowstone Road, Suite 420 Cheyenne, WY 82002

If you have questions, please call ESRD at 307-777-3527

